

To date, our jurisdiction has had great success with social distancing, self-isolation, and robust contact tracing in containing COVID-19. At the time of writing this, we have had a total of 962 cases with 15 deaths and enjoy an effective reproductive number of approximately 2.3 (recently increased from <1.0 because of a localized and contained outbreak). Fortunately, to date, our hospitals have not been overwhelmed like some of our Canadian and international peers. As such, we have not yet had to activate this model of care. We highly appreciate the data presented by our Italian colleagues that supports the feasibility of the convalescent part of our model. It remains to be seen how our multientry point model performs relative to theirs.

In summary, we applaud Bruni and colleagues (1) on their work and present a similar but more comprehensive hotel-based model of COVID-19 care. ■

Author disclosures are available with the text of this letter at www.atsjournals.org.

Mark E. Fenton, M.D., M.Sc., F.R.C.P.C.*
Kevin Wasko, M.A., M.D., C.C.F.P. (E.M.).
Vern Behl, M.D., C.C.F.P. (E.M.).
John Froh, B.Sc., M.D., C.C.F.P. (E.M.), F.C.F.P.
University of Saskatchewan
Saskatoon, Saskatchewan, Canada
and

Saskatchewan Health Authority
Saskatoon, Saskatchewan, Canada

Michelle Schmalenberg, B.Admin.
Saskatchewan Health Authority
Saskatoon, Saskatchewan, Canada

*Corresponding author (e-mail: mark.fenton@usask.ca).

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Reply to Fenton *et al.*

From the Authors:

We really thank Fenton and colleagues for their interest in our article (1) and the pleasing comments regarding our

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telemedicine-supported hotel accommodation model for patients with coronavirus disease (COVID-19).

Our project, which allowed 258 patients with COVID-19 to be discharged from the hospital to the hotel, was performed in the period from April 1 to May 31, 2020, during the Italian COVID-19 epidemic peak, when the number of infections was at its maximum, the need for hospital beds was urgent, and the future perspective of the outbreak was uncertain. The connection between the timing of such a model and the infection peak is a crucial aspect, to guarantee a rapid response to the epidemic and at the same time to contain unnecessary costs. Our timing was very appropriate for the Lazio region peak: the cost-effectiveness analysis of the project is ongoing.

Moreover, a decisive feature of this model is its flexibility: the capacity to modify the offered service, such as personnel, number of active rooms, and provision of other side services, in a fluid way adaptable day by day to contagions and resources guaranteed by different nations with different realities in terms of epidemiology and health systems enables this model to potentially fit to all the countries seriously affected by the pandemic to better cope with the outbreak.

Our model evolved over time: the number of nurses varied according to the number of hotel guests; physiotherapy and psychological counseling services were born following the needs that patients presented during their accommodation; the meal service was adapted to the health and cultural requirements of the patients, such as Easter or Ramadan time. Of course, this model should be adapted to the different sociocultural and epidemiological settings: if this type of management is to be efficient, the few “basic” requirements (e.g., isolation and feasibility of testing) will need to be mixed with other “additional” features (e.g., security and psychological support) to build the best solution, which will be different from country to country and within the same country during different phases of the epidemic.

Medical staff present in the hotel included geriatricians, normally operating in the continuity care service, who managed the in and out flow of patients, the swab timing, and the relationship with the public hygiene office that regulated the isolation conclusion. Patients’ arrival in the facility was subject to compliance with the inclusion criteria mentioned in the paper (1) to guarantee a good quality of accommodation and telemonitoring, despite the limited health resources that a hotel can guarantee compared with a hospital.

Three pulmonologist doctors provided medical availability 24 hours a day and were in charge of remote control of vital signs; a phone, an oximeter, and a thermometer were given to each patient with all the instructions for correctly sending parameters to the central platform. A telephone helpdesk support was made available to minimize the time patients required to familiarize themselves with the telemonitoring tools.

Our model ended up with 254 patients with negative severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) swabs who were discharged home: 4 patients who were still positive were transferred to other health facilities. Currently, the number of infections in Italy has greatly reduced, thus allowing the hotel to be converted back to its original function. The experience provided by such a useful project could enable a rapid reinstatement in case of need for possible COVID-19 second waves. For this reason, healthcare managers should define contractual arrangements with hotel facilities in advance to be ready to activate them quickly if needed.

We are very thankful to Fenton and colleagues for the interest received, delighted to see how our model has been reproduced

in other locations around the world, and intrigued by multiple possibilities to further expand it. ■

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Teresa Bruni, M.D.
Università Cattolica del Sacro Cuore
Roma, Italy

and
Imperial College London
London, United Kingdom

Ajit Lalvani, M.A., D.M., F.R.C.P., F.Med.Sci., F.F.P.H.
Imperial College London
London, United Kingdom

Luca Richeldi, M.D., Ph.D.*
Università Cattolica del Sacro Cuore
Roma, Italy

ORCID IDs: 0000-0003-0199-8629 (T.B.); 0000-0002-2396-246X (A.L.);
0000-0001-8594-1448 (L.R.).

*Corresponding author (e-mail: luca.richeldi@policlinicogemelli.it).

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Improving Lung Cancer Screening Uptake

To the Editor:

The recent article by Quaife and colleagues (1) and the accompanying editorial by Burnett-Hartman and Wiener (2) report the results of the LSUT (Lung Screen Uptake Trial) from London and provide comments from Boston. The trial is important because it provides evidence that there may be ways to improve the dismal uptake of lung cancer screening, especially in higher-risk, underserved populations. The editorialists point out some differences between the United Kingdom and United States, including the important fact that patient contact came from the individual primary care physician, which is in contrast to the approach used in the United States, where many patients do not have an identifiable primary care physician. There are other important factors, including the emphasis on the “Lung Health Check” rather than

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on more narrow lung cancer screening and the absence of copays or other financial disincentives for computed tomographic scans in the United Kingdom compared with the United States. In PLUSS (Pittsburgh Lung Screening Study) (3), we have also emphasized total lung health by providing annual spirometry, and we have eliminated financial barriers by waving all copays. We have also been using the electronic health record to identify potential candidates for lung screening. As our ability to obtain more information from the low-dose computed tomographic scans by radiomic advances, we hopefully can rebrand lung cancer screening in the United States, maybe as heart and lung screening, to facilitate more widespread use. ■

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David O. Wilson, M.D., M.P.H.*
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

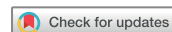
ORCID ID: 0000-0002-2635-7468 (D.O.W.).

*Corresponding author (e-mail: wilsondo@upmc.edu).

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Reply to Wilson

From the Authors:

We read Wilson’s response letter to both our LSUT (Lung Screen Uptake Trial) (1) and the accompanying editorial by Burnett-Hartman and Wiener (2) with great interest and value the insightful discussion they raise. Together we share in the challenge of achieving both equitable and informed uptake of low-dose computed tomography lung cancer screening by high-risk individuals, but the differences between the United Kingdom and United States that Wilson raises are important for how we intervene. The United Kingdom benefits from a coordinated and universal primary care system, and we appreciate that sending postal invitations directly from the individual’s primary care physician is a strategy that may not translate

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